Christopher Laseter, D.O.

Osteopathic Manipulative Medicine

PATIENT/PHYSICIAN MEDICARE FINANCIAL AGREEMENT

I,____________________________agree to be personally, financially liable for all charges, without any limits that otherwise would be imposed, for all Medicare covered services provided by Christopher Laseter, D.O., from the date of this contract.

I agree not to bill or ask my physician to bill Medicare, Medigap or other supplemental insurers for these services.

I understand that Medicare payment will not be made for Medicare services that otherwise would have been paid by Medicare.

I also understand that I retain the right to receive services from physicians and practitioners for whom Medicare coverage and payment would be available.

I understand that payment is due at the time services are rendered.

Furthermore, I am currently not facing an emergency or urgent health situation.

Signed:____
(Medicare beneficiary or legal representative)
Date:________________________

I, Christopher Laseter, D.O., acknowledge this contract and further state that I have not been excluded from Medicare.

Signed:________________________,D.O.
(physician)
Date:________________________

MEDICARE REQUIRES THAT THIS CONTRACT BE SIGNED BY ALL MEDICARE PATIENTS SEEING NONPARTICIPATING PHYSICIANS.

101 Good Drive, Suite # 4, Lancaster, Pennsylvania 17603 Phone 717-394-2071, FAX 717-394-2077